IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1002

NOTICE OF RULEMAKING - PROPOSED RULE

NOT OFFICIAL TEXT

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56- 202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Three public hearings concerning this rulemaking will be held as follows:

Wednesday, September 15, 2010 6:00 p.m. PDT	Wednesday, September 15, 2010 6:00 p.m. MDT	Wednesday, September 15, 2010 6:00 p.m. MDT
Dept. of Health & Welfare-Reg. 1 1120 Ironwood Drive, Suite 102 Lower Level Large Conf. Rm. Coeur d'Alene, ID	Dept. of Health & Welfare-Reg. 4 1720 Westgate Drive Suite A, Room 131 Boise, ID	Dept. Health & Welfare-Reg. 7 150 Shoup Avenue 2nd Floor, Large Conf. Rm. Idaho Falls, ID

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In 2008, the Department began meeting with stakeholder groups to redesign developmental disabilities (DD) benefits for children. This project is known as the "Children's System Redesign" and is sponsored by the Division of Medicaid and the Division of Family and Community Services. The Department is proposing a phased implementation of these redesigned benefits starting July 1, 2011. Implementation requirements are provided in Section 523 of this proposed docket.

In order to phase in these new benefits as seamlessly as possible, the Department is proposing that we continue to operate the current children's DD benefits concurrently with the redesigned children's DD benefits. To accomplish this we are proposing that the current requirements for developmental therapy, Intensive Behavioral Intervention (IBI), and other DDA services be moved from IDAPA 16.04.11, "Developmental Disabilities Agencies," to IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," in Sections 649 through 659 of this proposed docket.

The major restructuring for the Children's System Redesign provides the following: definitions, requirements for children's DD programs, including the new services and provider qualifications.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is cost-neutral.

Individualized budgets and limitations are being proposed for participants, using historical costs of developmental disabilities agency (DDA) services for children, to ensure the redesign of benefits remains cost-neutral. In addition, improved efficiencies of the redesign will safeguard against increasing program costs. Improvements include the addition of independent assessors and case managers to eliminate conflict of interest, and the creation of an array of outcome-based services and supports that align with varying health needs.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, informal negotiated rulemaking was conducted with stakeholders in a meeting held on Wednesday, July 14, 2010. The notice for this negotiated rulemaking published in the July 7, 2010, Idaho Administrative Bulletin, Vol. 10-7, p. 26.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules under this docket.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lauren Ertz at (208) 287-1169.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2010.

DATED this 17th day of August, 2010.

Tamara Prisock
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THE FOLLOWING IS THE PROPOSED TEXT FOR DOCKET NO. 16-0310-1002

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Section 009.04 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (3-19-07)

02. Availability to Work or Provide Service. (3-19-07)

a. The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant record. (3-19-07)

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. (3-19-07)

03. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-19-07)

04. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (3-19-07)

a. Adult Day Care Providers. The criminal history and background check requirements applicable to providers of adult day care as provided in Sections 329 and 705 of these rules. (4-2-08)

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. (4-2-08)

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. (4-2-08)

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Sections 329 and 705 of these rules. (4-2-08)

e. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-2-08)

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. (4-2-08)

g. Crisis Intervention Providers. The criminal history and background check requirements applicable to crisis intervention providers as provided in Section 685 of these rules. ( )

~~g~~**h.** Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. (4-2-08)

~~h~~**i.** Day Rehabilitation Providers. The criminal history and background check requirements applicable to day rehabilitation providers as provided in Section 329 of these rules. (4-2-08)

~~i~~**j.** Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.04~~3.1~~21, "~~Rules Governing~~ Developmental Disabilities Agencies (DDA)," Section 009. ~~(3-19-07)~~( )

~~j~~**k.** Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. (4-2-08)

~~k~~**l.** Mental Health Clinics. The criminal history and background check requirements applicable to mental health clinic staff as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 714. (3-19-07)

~~l~~**m.** Personal Assistance Agencies Acting As Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (3-19-07)

~~m~~**n.** Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (3-19-07)

~~n~~**o.** Psychiatric Consultation Providers. The criminal history and background check requirements applicable to psychiatric consultation providers as provided in Section 329 of these rules. (4-2-08)

~~o~~**p.** Psychosocial Rehabilitation Agencies. The criminal history and background check requirements applicable to psychosocial rehabilitation agency employees as provided in Subsection 130.02 of these rules. (3-19-07)

~~p~~**q.** Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. (4-2-08)

~~q~~**r.** Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. ~~(4-2-08)~~( )

~~r~~**s.** Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (3-19-07)

~~s~~**t.** Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. (4-2-08)

u. Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. ( )

(BREAK IN CONTINUITY OF SECTIONS)

013. DEFINITIONS P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Patient Day. For a nursing facility or an ICF/ID, a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care will be deemed to exist. (3-19-07)

02. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. Patient. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (5-8-09)

05. Personal Assistance Services (PAS). Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

06. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants.” (3-19-07)

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility’s rate for the next quarter. (3-19-07)

09. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-19-07)

10. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. **PRM**. The Provider Reimbursement Manual. (3-19-07)

12. **Property**. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

13. **Property Costs**. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

14. **Property Rental Rate**. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/ID facilities. (3-19-07)

15. **Provider**. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

16. **Provider Agreement**. An written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

17. **Provider Reimbursement Manual (PRM)**. The Providers Reimbursement Manual, a federal publication which specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, which are incorporated by reference in Section 004 of these rules. (3-19-07)

18. **Psychologist, Licensed**. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

19. **Psychologist Extender**. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

20. **Public Provider**. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

21. **Raw Food**. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

22. **Reasonable Property Insurance**. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

23. **Recreational Therapy (Services)**. Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, training for Special Olympics, and special day parties (birthday, Christmas, etc.). (3-19-07)

~~***24.*** ***Regional Medicaid Services (RMS)***. *Regional offices of the Division of Medicaid.* ***(3-19-07)***~~

2~~5~~**4.** **Regional Nurse Reviewer (RNR)**. A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

2~~6~~5. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Professional Nurse and who meets all the applicable requirements to practice as a licensed professional nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

2~~7~~6. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider. (3-19-07)

2~~8~~7. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

2~~9~~8. Residential Care or Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Care or Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-19-07)

***30*29. Resource Utilization Groups (RUG)**. A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-2-08)

3~~1~~0. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

3~~2~~1. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

3~~3~~2. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

3~~4~~3. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

3~~5~~4. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

3~~6~~5. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)

3~~7~~6. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

3~~8~~7. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

3~~9~~8. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

***40*39. Uniform Assessment**. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

4~~1~~0. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Rules Governing Uniform Assessments of State-Funded Clients." (3-19-07)

4~~2~~1. Utilities. All expenses for heat, electricity, water and sewer. (3-19-07)

~~43~~2. Utilization Control (UC). A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

~~44~~3. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

~~45~~4. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

026. SELECTIVE CONTRACTING.
The Department may contract with a limited number of providers of certain Medicaid products and services~~,~~ *~~including: dental services, eyeglasses, transportation, and some medical supplies~~*. *~~(3-19-07)~~*(____)

(BREAK IN CONTINUITY OF SECTIONS)

503. DEVELOPMENTAL DISABILITY DETERMINATION: TEST INSTRUMENTS.
A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (3-19-07)

01. Test Instruments For Adults. Unless contra-indicated, the following test instruments or subsequent revisions must be used to determine eligibility: (3-19-07)

a. Cognitive: Wechsler Adult Intelligence Scale-Third Edition (WAIS-III). (3-19-07)

b. Functional: Scales of Independent Behavior-Revised (SIB-R). (3-19-07)

02. Test Instruments for Children. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills, be racially and culturally non-discriminatory, and be conducted in settings that are typically comfortable and familiar to the child. Unless contraindicated, test instruments such as the following must be used with children: (3-19-07)

a. Cognitive: (3-19-07)

i. Bayley Scales of Infant Development, Third Edition (BSID-III) for ages birth through forty-two (42) months; (3-19-07)

ii. Stanford Binet Intelligence Scales, Fifth Edition (SB5) for ages two (2) years through adult; (3-19-07)

iii. Wechsler Preschool and Primary Scale of Intelligence -Third Edition (WPPSI-III) for ages two (2) years, six (6) months to seven (7) years, three (3) months; (3-19-07)

iv. Wechsler Intelligence Scale for Children - Fourth Edition (WISC-IV) for ages six (6) through sixteen (16) years, eleven (11) months; or (3-19-07)

v. Wechsler Adult Intelligence Scale - Third Edition (WAIS-III) for ages sixteen (16) years to adult. (3-19-07)

b. Functional~~:~~ ~~(3-19-07)~~

~~*i. American Association on Mental Retardation Adaptive Behavior Scale: School (ABS-S) for ages three (3) through twenty one (21) years;* (3-19-07)~~

~~*ii. Battelle Developmental Inventory, 2nd Edition (BDI-2) for ages birth to ninety-five (95) months;* (3-19-07)~~

~~*iii. Developmental Profile II (DP-II) for ages birth through twelve (12) years;* (3-19-07)~~

~~*iv.* Scales of Independent Behavior (SIB-R) for ages birth through adult~~:~~. ~~(3-19-07)~~( )

~~*v. Vineland Adaptive Behavior Scales (VABS) for ages birth to eighteen (18) years, eleven (11) months;* (3-19-07)~~

~~*vi. Mullen Scales of Early Learning (MSEL) for ages birth to three (3) years;* (3-19-07)~~

~~*vii. Preschool Language Scale - 3 (PLS-3) for ages birth to three (3) years;* (3-19-07)~~

~~*viii. Peabody Developmental Motor Scales for ages birth to three (3) years; or* (3-19-07)~~

~~*ix. Receptive-Expressive Emergent Language Scale - Third Edition (REEL-3) for ages birth to three (3) years.* (3-19-07)~~

(BREAK IN CONTINUITY OF SECTIONS)

511. INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY - COVERAGE AND LIMITATIONS. The scope of these rules defines prior authorization for the following Medicaid behavioral health services for adults: (3-19-07)

01. DD Waiver Services. DD Waiver services as described in Sections 700 through 719 of these rules; and (3-29-10)

02. Developmental Disability Agency Services. Developmental Disabilit~~y~~ies Agency services as described in Sections 6~~50~~49 through 6~~60~~59 of these rules and IDAPA 16.0~~4~~3.~~1~~21, "Developmental Disabilities Agencies (DDA)"; and ~~(3-19-07)~~( )

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

516. -- 5~~7~~19. (RESERVED).

SUB-PART: CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (SECTIONS 520 THROUGH 528)

520. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA).
The purpose of the children's DD Prior Authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of service, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. ( )

521. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. ( )

01. Action Plan. An initial or annual plan of service that identifies all services and supports based on a family-centered planning process and is developed for providing DD services to children ages birth through seventeen (17). ( )

02. Assessment. A process that is described in Section 522 of these rules for program eligibility and in Section 526 of these rules for plan of service. ( )

03. Baseline. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. ( )

04. Child. A person who is under the age of eighteen (18) years. ( )

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. ( )

06. Family-Centered Planning Process. A process facilitated by the plan developer, comprised of the child participant (unless otherwise determined by the family-centered planning team), parent or legal guardian, and individuals significant to the participant who collaborate with the participant to develop the plan of service. ( )

07. Family-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the parent or legal guardian and the plan developer. The family-centered planning team may include others identified by the family or agreed upon by the family and the Department as important to the process. ( )

08. Individualized Family Service Plan (IFSP). An initial or annual plan of service, developed by the Department or its designee, for providing early intervention services to children birth to age three (3). This plan must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C. The IFSP may serve as the action plan when meeting all of the components of the action plan. ( )

09. Level of Support. An assessment score derived from a functional assessment that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. ( )

10. Medical, Social, and Developmental Assessment Summary. A form used by the Department to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. ( )

11. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports based on a family-centered planning process and who oversees the provision of services. ( )

12. Plan of Service. An initial or annual plan that identifies all services and supports based on a

family-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. For the purpose of these rules, the plan of service is referring to the Action Plan and Individual Family Service Plan (IFSP). ( )

13. **Practitioner of the Healing Arts, Licensed**. A licensed physician, physician assistant, or nurse practitioner. ( )

14. **Prior Authorization (PA)**. A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. ( )

15. **Provider Status Review**. The written documentation which providers are required to complete that identifies the participant's progress toward goals defined in the plan of service. ( )

16. **Right Care**. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. ( )

17. **Right Place**. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. ( )

18. **Right Price**. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. ( )

19. **Right Outcomes**. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. ( )

20. **Services**. Services paid for by the Department that enable the individual to reside safely and effectively in the community. ( )

522. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: ELIGIBILITY DETERMINATION.

The Department will make the final determination of a child's eligibility, based upon the assessments administered by the Department. Initial and annual assessments must be performed by the Department or its contractor. The purpose of the eligibility assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules, to determine a participant's eligibility for children's home and community-based state plan option services in accordance with Section 662 of these rules, and to determine a participant's eligibility for ICF/ID level of care for children's waiver services in accordance with Section 682 of these rules. ( )

01. **Initial Eligibility Assessment**. For new applicants, an assessment must be completed by the Department or its contractor within thirty (30) days from the date a complete application is submitted. ( )

02. **Annual Eligibility Determination**. Eligibility determination must be completed annually for current participants. The assessor must reassess the participant, or establish and document that the existing assessments reflect the participant's current level of care needs. At least sixty (60) days before the expiration of the current plan of service: ( )

a. The eligibility determination process must be completed to determine level of care needs; and ( )

b. The assessor must provide the results of the eligibility determination to the participant. ( )

03. **Determination of Developmental Disability Eligibility**. ( )

a. The assessments that are required and completed by the Department or its contractor for determining a participant's eligibility for developmental disabilities services must include: ( )

i. Medical, Social, and Developmental Assessment Summary; ( )

ii. A functional assessment which reflects the participant's current functioning. The Department or its contractor will administer a functional assessment for use in initial eligibility determination of developmental disability eligibility. Thereafter, a new functional assessment will be required if the assessor determines that additional documentation is necessary to determine the participant's level of care criteria: and ( )

iii. A medical assessment which contains medical information that accurately reflects the current status of the participant and established categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code. ( )

b. The participant must provide the results of psychometric testing if eligibility for developmental disabilities services is based on intellectual disability and he has no prior testing, or prior testing is inconclusive or invalid. Initial eligibility determinations also require documentation of diagnosis for participants whose eligibility is based on developmental disabilities other than intellectual disability. ( )

04. ICF/ID Level of Care Determination for Waiver Services. The Department or its contractor will determine ICF/ID level of care for children in accordance with Section 584 of these rules. ( )

05. Determination for Children's Home and Community Based State Plan Option. The Department or its contractor will determine that a child meets the established criteria necessary to receive children's home and community based state plan option services in accordance with Section 662 of these rules. ( )

523. TRANSITION TO NEW CHILDREN'S DEVELOPMENTAL DISABILITY BENEFITS.

01. Phase-in Schedule. To transition to the new benefits under Sections 520 through 528, Sections 660 through 666, and Sections 680 through 686 of these rules, a child will be phased in to the new benefits by order of his birthdate. ( )

02. Notification. During the phased-implementation, the Department will notify a family three (3) months prior to their child's birthdate. ( )

03. New Applicants. A new applicant entering the system will be enrolled in the new children's DD benefit programs. ( )

04. Opportunity for Early Enrollment. A family may opt to transition their child to the new benefits prior to their child's birthdate. The Department will accept application for a family choosing to opt-in early, but transitioning a child at his scheduled transition date will be the Department's top priority. ( )

05. Choosing a Path. A child will not be able to receive both the new children's HCBS state plan option and children's waiver services listed in Section 660 through 666 and 680 through 688, at the same time he is receiving the old DDA services listed in Section 649 through 659. ( )

524. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid developmental disabilities services for children: ( )

01. Children's Home and Community Based State Plan Option Services. Children's home and community based state plan option services as described in Sections 660 through 666 of these rules; and ( )

02. Children's DD Waiver Services. Children's DD waiver services as described in Sections 680 through 686 of these rules. ( )

525. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: PROCEDURAL REQUIREMENTS.

01. Documentation Requirements Prior to the Plan of Service. Prior to the development of the plan

of service, the plan developer will gather the following information to guide the family-centered planning process: ( )

a. Eligibility Determination Documentation. Eligibility determination documentation completed by the Department or its contractor as defined in Subsection 522.03 of these rules. ( )

b. History and Physical. A current history and physical completed by a practitioner of the healing arts is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. ( )

c. Additional Information. Assessments and information related to the participant's medical conditions, risk of deterioration, living conditions, individual goals, and behavioral or psychiatric needs. ( )

526. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATIONS: PLAN OF SERVICE PROCESS.
In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 527 of these rules and must identify all services and supports. The participant and his parent or legal guardian may develop their own plan or designate a paid or non-paid plan developer. The plan of service must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. ( )

01. Qualifications of a Paid Plan Developer. The paid plan developer must be provided by the Department or its contractor. ( )

02. Plan of Service Development. The plan of service must be developed with the parent or legal guardian. With the parent or legal guardian's consent, the family-centered planning team may include other family members or individuals who are significant to the participant. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The plan of service must be submitted to the Department within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, provider payments may not be authorized. ( )

03. Prior Authorization for Services Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. ( )

04. No Duplication of Services. The plan developer is responsible for monitoring the services on the plan of service and must ensure that there is no duplication of services. ( )

05. Plan Monitoring. The parent or legal guardian and plan developer must monitor the plan. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months. The plan developer must meet face-to-face with the participant at least annually. Plan monitoring must include the following: ( )

a. Review of the plan of service with the parent or legal guardian to identify the current status of programs and changes if needed; ( )

b. Contact with service providers to identify barriers to service provision; ( )

c. Discuss with parent or legal guardian satisfaction regarding quality and quantity of services; and ( )

d. Review of provider status reviews. ( )

06. Provider Status Reviews. The following service providers, listed in Subsections 526.06.a. and

526.06.b. of this rule, must report to the plan developer the participant's progress toward goals. The provider must complete a six (6) month and annual provider status review. The semi-annual and annual provider status reviews for: ( )

a. Habilitative supports must report the progress toward the identified goals listed on the plan of service, and must demonstrate the continued need for the service. ( )

b. Habilitative intervention and family training services must include: ( )

i. The initial baseline; ( )

ii. Measurement that reflects the present status of the participant; ( )

iii. Progress towards the identified objectives listed on the plan of service; ( )

iv. Statement that describes the continued need for the service; ( )

v. Modifications made to the implementation plan, if applicable; and ( )

vi. Recommendations for revisions to the plan, if applicable. ( )

07. Content of the Plan of Service. The plan of service must identify, at a minimum, the type of service to be delivered, goals to be addressed within the plan year, target dates, intervention objectives, and methods for collaboration. ( )

08. Informed Consent. The participant and his parent or legal guardian must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. ( )

09. Provider Implementation Plan. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. ( )

a. Exceptions. An implementation plan is not required for waiver providers of: ( )

i. Respite care; ( )

ii. Habilitative Supports; ( )

iii. Family Education; and ( )

iv. Therapeutic Consultation. ( )

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. ( )

c. Documentation of Changes. Documentation of implementation plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the signature of the person making the change complete with his title and the date signed. ( )

11. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of service requires a parent’s or legal guardian's signature and may be subject to prior authorization by the Department. ( )

12. **Annual Reauthorization of Services**. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. ( )

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: ( )

i. Notify the providers who appear on the plan of service of the annual review date. ( )

ii. Obtain a copy of the current annual provider status review from each provider for use by the family-centered planning team. Each provider status review must meet the requirements in Subsection 526.06 of these rules. ( )

iii. Convene the family-centered planning team to develop a new plan of service. ( )

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 520 and 526 of these rules. ( )

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. ( )

d. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. ( )

e. Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules. ( )

13. **Complaints and Administrative Appeals**. ( )

a. Complaints. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Department. ( )

b. Administrative Appeals. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

527. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis based on a participant budget. ( )

01. **Individualized Budget**. The Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The Department will monitor the budget setting methodology on an ongoing basis to ensure that participant needs are accurately reflected in the methodology. ( )

02. **Participant Notification of Budget Amount**. The Department notifies each participant of his set budget amount. The notification will include how the participant may appeal the set budget amount. ( )

03. **Annual Re-Evaluation**. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget. ( )

528. CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to ensure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may terminate authorization of service for providers who do not comply with the corrective action plan. ( )

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. ( )

03. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. ( )

04. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. ( )

529. -- 579. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

634. -- 649. (RESERVED).

650. DEVELOPMENTAL DISABILITIES AGENCIES (DDA).
Under 42 CFR 440.130(d), the Department will pay for rehabilitative services including medical or remedial services provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. (3-19-07)

~~*651. (RESERVED).*~~

652. DEVELOPMENTAL DISABILITIES AGENCY (DDA) SERVICES: ELIGIBILITY.

01. DDA Services Eligibility. Prior to receiving services in a DDA an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code. ~~*(3-19-07)*~~( )

02. Intensive Behavioral Intervention (IBI) Service Eligibility. IBI is available to children with developmental disabilities through the month of their twenty-first birthday, who have the following characteristics: ( )

a. Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified by the Department; and ( )

b. A severe deficit, defined as equivalent to fifty percent (50%) or less of chronological age, in at least one (1) of the following areas: ( )

i. Verbal and nonverbal communication as evidenced by the SIB-R Social Interaction & Communication Skills cluster score; ( )

ii. Social interaction as evidenced by the SIB-R Social Interaction subscale score; or ( )

iii. Leisure and play skills as evidenced by the SIB-R Home/Community Orientation subscale score. ( )

65~~3~~1. DDA SERVICES: COVERAGE REQUIREMENTS AND LIMITATIONS. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts. The following therapy services are reimbursable when provided in accordance with these rules. ( )

01. ~~***Requirement for Plan of Service and Prior Authorization***~~ **Required DDA Services**. Each DDA is required to provide developmental therapy; in addition, each DDA must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. Developmental therapy must be provided by qualified employees of the agency. Psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy must either be provided by qualified employees of the agency or through a formal written agreement. ~~*(3-19-07)*~~( )

a. ~~*All therapy services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Developmental Disabilities Agencies."*~~ Sufficient Quantity and Quality. All required services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified individuals in accordance with the requirements in Section 420 of these rules. ~~*(3-19-07)*~~( )

b. ~~*All therapy services for adults with developmental disabilities must be identified on the plan of service and prior authorized as described in Sections 507 through 520 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies."*~~ When a Required Service Is Not Available. When a required service, other than developmental therapy, is not provided by the agency due to a documented shortage of available providers in a specific geographic area, the DDA must document its effort to secure the service or facilitate the referral for the needed service, including notifying the service coordinator, when the participant has one. ~~*(3-29-10)*~~( )

02. ~~***Assessment and Diagnostic Services***~~. ~~*Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies":*~~ **Requirements to Deliver Developmental Therapy**. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on a comprehensive developmental assessment completed prior to the delivery of developmental therapy. ~~*(3-19-07)*~~( )

a. ~~*Comprehensive Developmental Assessment;*~~ Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. ~~*(3-19-07)*~~( )

b. ~~*Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the twelve*~~

~~(12) hour limitation described in this subsection;~~ Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. ~~(3-19-07)~~( )

c. ~~Occupational Therapy Assessment~~ Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. ~~(3-19-07)~~( )

d. ~~Physical Therapy Assessment;~~ Settings for Developmental Therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. ~~(3-19-07)~~( )

e. ~~Speech and Language Assessment;~~ Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served. ~~(3-19-07)~~( )

~~**f.** Medical/Social History; and (3-19-07)~~

~~**g.** Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (3-19-07)~~

03. Psycho~~T~~therapy Services. ~~Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies." The following therapy services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies."~~ The following psychotherapy services must be available through each agency and based on assessment(s) conducted by the professional qualified to deliver the service: ~~(3-19-07)~~( )

a. ~~Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy.~~ Individual psychotherapy; ~~(3-19-07)~~( )

b. ~~Psychotherapy Services. Psychotherapy services, alone or in combination with supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, and include:~~ Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and ~~(3-19-07)~~( )

~~**i.** Individual psychotherapy; (3-19-07)~~

~~**ii.** Group psychotherapy; and (3-19-07)~~

~~**iii.** Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-19-07)~~

c. ~~Supportive Counseling. Supportive counseling must only be delivered on an individualized, one-to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty five (45) hours in a calendar year.~~ Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time. ~~(3-19-07)~~( )

d. ~~Speech Language Pathology Services. Speech language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739.~~ Psychotherapy services, alone or in combination with supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, including individual, group, and family-centered. ~~(4-2-08)~~( )

e. ~~*Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739.* (4-2-08)~~ Psychotherapy services must be provided by one (1) of the following qualified professionals: ( )

i. Licensed Psychiatrist; ( )

ii. Licensed Physician; ( )

iii Licensed Psychologist; ( )

iv. Licensed Clinical Social Worker; ( )

v. Licensed Clinical Professional Counselor; ( )

vi. Licensed Marriage and Family Therapist; ( )

vii. Certified Psychiatric Nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree; ( )

viii. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified above under Subsections 651.03.i. through 651.03.vii. of this rule; ( )

ix. Registered Marriage and Family Therapist Intern whose provision of psychotherapy is supervised as described in Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

x. Licensed Masters Social Worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; or ( )

xi. A Psychologist Extender, registered with the Bureau of Occupational Licenses, whose provision of psychotherapy is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ( )

~~***f.*** *Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739.* (4-2-08)~~

~~***g.*** *Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months.* (3-19-07)~~

~~***i.*** *The DDA must receive prior authorization from the Department prior to delivering IBI services.* (3-19-07)~~

~~***ii.*** *IBI must only be delivered on an individualized, one-to-one basis.* (3-19-07)~~

~~***h.*** *Intensive Behavioral Intervention (IBI) Consultation. IBI consultation is included in the thirty six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation.* (3-19-07)~~

~~***i.*** *Collateral Contact. Collateral contact is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable.* (3-19-07)~~

~~***j.*** *Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other*~~

~~*practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service.*~~ ~~*(3-19-07)*~~

04. ~~***Excluded***~~ **Occupational Therapy Services**. ~~*The following services are excluded for Medicaid payments:*~~ Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Occupational therapy services must be available and provided by a licensed occupational therapist and be based on the results of an occupational therapy assessment completed in accordance with Section 655 of these rules. ~~*(3-19-07)*~~( )

~~***a.*** *Vocational services;* *(3-19-07)*~~

~~***b.*** *Educational services; and* *(3-19-07)*~~

~~***c.*** *Recreational services.* *(3-19-07)*~~

05. ~~***Limitations on DDA***~~ **Physical Therapy Services**. ~~*Therapy services may not exceed the limitations as specified below.*~~ Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Physical therapy services must be available and provided by a licensed physical therapist and be based on the results of a physical therapy assessment completed in accordance with Section 655 of these rules. ~~*(3-19-07)*~~( )

~~***a.*** *The combination of therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules must not exceed twenty-two (22) hours per week.* *(1-1-09)T*~~

~~***b.*** *Therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week.* *(3-19-07)*~~

~~***c.*** *When a HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week.* *(3-19-07)*~~

~~***d.*** *Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency.* *(3-19-07)*~~

06. Speech-Language Pathology Services. Speech-language pathology services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. Speech–language pathology services must be available and provided by a qualified speech-language pathologist, as defined in these rules, and be based on the results of a speech and language assessment completed in accordance with Section 655 of these rules. ( )

07. Optional Services. DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, collateral contact, Intensive Behavioral Intervention (IBI), and supportive counseling. All services must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. ( )

08. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency, and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. ( )

09. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must include a history, a current mental status examination, and offer recommendations for treatment interventions needed, if any. If the

interview exam results in a recommendation for additional intervention and the recommendation is accepted by the participant and his parent or legal guardian, if applicable, the recommendation must be incorporated into the participant's plan of service with the type, amount, frequency, and duration of service specified. ( )

a. Physician Requirement. In order for a DDA to conduct a psychiatric diagnostic interview, the agency must have a physician on contract for the purpose of overseeing the services on the plan. ( )

b. On Plan of Service. A psychiatric diagnostic interview must be incorporated into the participant's plan of service. ( )

c. Staff Qualifications. A psychiatric diagnostic interview must be conducted by one (1) of the following professionals, in direct face-to-face contact with the participant: ( )

i. Psychiatrist; ( )

ii. Physician or other practitioner of the healing arts; ( )

iii. Psychologist; ( )

iv. Clinical social worker; or ( )

v. Clinical professional counselor. ( )

10. Community Crisis Supports. Community crisis supports are interventions for adult participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. DDAs that choose to provide these services must do so in accordance with Sections 507 through 515 of these rules. ( )

11. Collateral Contact. Collateral contact is consultation with or treatment direction given to a person with a primary relationship to a participant for the purpose of assisting the participant to live in the community. Collateral contact must be: ( )

a. Conducted by Agency Professionals. Be conducted by agency professionals qualified to deliver services and be necessary to gather and exchange information with individuals having a primary relationship to the participant. ( )

b. Face to Face or by Telephone. Be conducted either face-to-face or by telephone when telephone contact is the most expeditious and effective way to exchange information. Collateral contact does not include general staff training, general staffings, regularly scheduled parent-teacher conferences, general parent education, or treatment team meetings, even when the parent is present. ( )

c. On the Plan of Service. Have a goal and objective stated on the plan of service that identifies the purpose and outcome of the service and is conducted only with individuals specifically identified on the plan of service. Program Implementation Plans are not required for collateral contact objectives. ( )

12. Intensive Behavioral Intervention. DDA's that choose to offer Intensive Behavioral Intervention (IBI) must provide IBI services in accordance with Sections 656 of these rules. ( )

a. IBI is limited to a lifetime limit of thirty-six (36) months. ( )

b. The DDA must receive prior authorization from the Department prior to delivering IBI services. ( )

c. IBI must only be delivered on an individualized, one-to-one (1 to 1) basis. ( )

d. Established Developmental Therapy Program. After July 1, 2006, agencies must have provided developmental therapy for at least one (1) year and not be operating under a provisional certification prior to

providing IBI services. ( )

e. Exception. Agencies that were providing IBI services prior to July 1, 2006, are exempt from the requirement under Subsection 651.12.d. of these rules. ( )

f. IBI Consultation. IBI consultation, as described in Section 656 of these rules, is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. ( )

13. Supportive Counseling. Supportive counseling must only be delivered on an individualized, one to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year. ( )

a. Psychological Assessment. The initial and ongoing need for the service of supportive counseling must be recommended in a current psychological assessment. ( )

b. On Plan of Service. Supportive counseling must be provided in accordance with the requirements for the plan of service. The type, amount, frequency, and duration of this service must be specified on the plan of service. ( )

c. Staff Qualifications. Supportive counseling must be provided by a professional listed under Subsection 651.03.e. of these rules or by a licensed social worker (LSW). ( )

14. Excluded Services. The following services are excluded for Medicaid payments: ( )

a. Vocational services; ( )

b. Educational services; and ( )

c. Recreational services. ( )

15. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. ( )

a. The combination of therapy services listed in Subsections 651.02 through 651.06 and 651.12 and 651.13 of these rules must not exceed twenty-two (22) hours per week. ( )

b. Therapy services listed in Subsections 651.02 through 651.06 and 651.12 and 651.13 of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week. ( )

c. When an HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. ( )

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. ( )

REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES AGENCIES PROVIDING SERVICES (Sections 652 through 659)

652. REQUIREMENTS FOR A DDA PROVIDING SERVICES TO PERSONS EIGHTEEN YEARS OF AGE OR OLDER.

This Section does not apply to adults who receive IBI or additional DDA services prior authorized under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program as described in IDAPA 16.03.09, "Medicaid

Basic Plan Benefits." DDAs must comply with the requirements under Section 653 of these rules for those adults. ( )

01. Eligibility Determination. Prior to the delivery of any DDA services, the person must be determined to be eligible as defined under Section 66-402, Idaho Code, for DDA services. ( )

a. For persons seeking Medicaid-funded DDA services who are eighteen (18) years of age or older, the Department or its designee determines eligibility for services. ( )

b. For persons eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 653.01 of these rules. ( )

02. Intake. ( )

a. For participants eighteen (18) years of age or older and who are not listed under Subsection 652.01.b prior to the delivery of any Medicaid-funded DDA services: ( )

i. The Department or its designee will have provided the DDA with current medical, social, and developmental information; and ( )

ii. The participant must have an ISP that is authorized in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. ( )

b. Participants eighteen (18) years of age or older receiving DDA services and who are using the Home and Community Based Services (HCBS) Waiver for the Aged and Disabled (A&D), State Plan PCS, or are living in a nursing facility must: ( )

i. Have DDA services prior authorized by the Department or its designee; and ( )

ii. DDAs must complete an Individual Program Plan (IPP) that meets the standards described in Subsections 653.04 through 653.06 of these rules. IPPs for these individuals do not require the signature of a physician or other practitioner of the healing arts. ( )

c. For participants eighteen (18) years of age or older who are not Medicaid participants, the DDA must follow the requirements under Subsection 653.02 of these rules. ( )

03. Assessments. Requirements for assessments are found under Sections 600 through 605 of these rules. ( )

04. Individual Service Plan (ISP). For participants eighteen (18) years of age or older any services provided by the DDA must be included on the plan of service and be prior authorized by the Department or its designee before a participant can receive the service from the agency. ( )

05. Documentation of Plan Changes. Documentation of changes in the required plan of service or Program Implementation Plan must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If there are changes to a Program Implementation Plan that affect the type or amount of service on the plan of service, an addendum to the plan of service must be completed. ( )

653. REQUIREMENTS FOR A DDA PROVIDING SERVICES TO CHILDREN AGES THREE THROUGH SEVENTEEN AND ADULTS RECEIVING IBI OR ADDITIONAL DDA SERVICES PRIOR AUTHORIZED UNDER THE EPSDT PROGRAM.

01. Eligibility Determination. Prior to the delivery of any DDA services, the DDA must determine and document the participant's eligibility in accordance with Section 66-402, Idaho Code. For eligibility determination, the following assessments must be obtained or completed by the DDA: ( )

a. Medical Assessment. This must contain medical information that accurately reflects the current status of the person and establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code; or ( )

b. Psychological Assessment. If the medical assessment does not establish categorical eligibility, the DDA must obtain or conduct a psychological assessment that accurately reflects the current status of the person and establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code. ( )

c. Standardized Comprehensive Developmental Assessment. This must contain developmental information regarding functional limitations that accurately reflects the current status of the person and establishes functional eligibility based on substantial limitations in accordance with Section 66-402(5)(b), Idaho Code. ( )

02. Intake. The DDA must obtain information that accurately reflects the current status and needs of the participant prior to the delivery of services. ( )

a. The person must have been determined by the DDA to be eligible for DDA services. ( )

b. The DDA must obtain or complete a comprehensive medical and medical/social history. ( )

03. Assessments. Requirements for assessments are found under Subsections 655.02 through 655.05 of these rules. ( )

04. Individual Program Plan (IPP) Definitions. The delivery of each service on a plan of service must be defined in terms of the type, amount, frequency, and duration of the service. ( )

a. Type of service refers to the kind of service described in terms of: ( )

i. Discipline; ( )

ii. Group, individual, or family; and ( )

iii. Whether the service is home, community, or center-based. ( )

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. ( )

c. Frequency of service is the number of times service is offered during a week or month. ( )

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. ( )

05. Individual Program Plan (IPP). For participants three (3) through seventeen (17) years of age and for adults receiving EPDST services, the DDA is required to complete an IPP. ( )

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. ( )

b. The planning process must include the participant and his parent or legal guardian, if applicable, and others the participant or his parent or legal guardian chooses. The participant's parent or legal guardian must sign the IPP indicating his participation in its development. The parent or legal guardian must be provided a copy of the completed IPP. If the participant and his parent or legal guardian are unable to participate, the reason must be documented in the participant's record. A physician or other practitioner of the healing arts and the parent or legal guardian must sign the IPP prior to initiation of any services identified within the plan, except as provided under Subsection 652.02.b.ii. of these rules. ( )

c. The planning process must occur at least annually, or more often if necessary, to review and update

the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations must be signed by the physician or other practitioner of the healing arts and maintained in the participant's file. A parent or legal guardian must sign the IPP prior to initiation of any services identified within the plan. ( )

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. ( )

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: ( )

i. The participant's name and medical diagnosis; ( )

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; ( )

iii. The dated signature of the physician or other practitioner of the healing arts indicating his recommendation of the services on the plan; ( )

iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; ( )

v. A list of the participant's current personal goals, interests and choices; ( )

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences. An IPP objective must be developed for each priority need; ( )

vii. A list of measurable behaviorally stated objectives, which correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; ( )

viii. The discipline professional or Developmental Specialist responsible for each objective; ( )

ix. The target date for completion of each objective; ( )

x. The review date; and ( )

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include integrated classrooms, community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. ( )

06. Documentation of Plan Changes. Documentation of required plan of service or Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: ( )

a. The reason for the change; ( )

b. Documentation of coordination with other services providers, where applicable; ( )

c. The date the change was made; and ( )

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant or the participant's parent or legal guardian, if applicable. Changes in type, amount, or duration of services require written authorization from a physician or other practitioner of the healing arts and the participant or the participant's parent or legal guardian prior to the change. If the signatures of the participant or the parent or legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. ( )

654. ~~*655. (RESERVED)*~~ **REQUIREMENTS FOR A DDA PROVIDING SERVICES TO CHILDREN BIRTH TO THREE YEARS OF AGE (INFANT TODDLER).**
Services provided by a DDA to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include: adherence to procedural safeguards and time lines, use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs), provision of early intervention services in the natural environment, transition planning, and program enrollment and reporting requirements. For children birth to age three (3), the IFSP will be used in lieu of the Individual Program Plan (IPP). ( )

01. Eligibility Determination. For a child birth to three (3) years of age, prior to the delivery of any DDA services: ( )

a. In accordance with 34 CFR 303.321(e), the Department's regional Infant Toddler Program will determine eligibility for DDA services in accordance with Section 66-402, Idaho Code. ( )

b. Upon request from the DDA, and after receiving consent from the parent or legal guardian for release of information, the Department's regional Infant Toddler Program will provide the DDA with documentation of the child's eligibility including a copy of the current IFSP, addendum(a) to the IFSP, assessments, and service records related to current DDA services. ( )

02. Intake. Prior to the delivery of DDA services: ( )

a. The DDA must obtain both a copy of the current IFSP and a copy of all current assessment(s) used by the Department's regional Infant Toddler Program to determine eligibility for DDA services; and ( )

b. The DDA must conduct a meeting with the child's family, in cooperation with the child's service coordinator, to review the current IFSP and confirm the family's resources, priorities, and concerns with regard to the child's current developmental status and therapeutic needs. ( )

03. Individualized Family Service Plan (IFSP). The Department or its designee will develop the initial IFSP for each eligible child, birth to three (3) years of age. Each DDA that provides DDA services to an eligible child, birth to three (3) years of age, must implement services according to the IFSP for that child as required by the Individuals with Disabilities Education Act, (P.L. 108-446, December 2004), Part C, Section 636 (d) and Title 16, Chapter 1, Idaho Code. The DDA must use the Department-approved IFSP form in accordance with 34 CFR 303.344. The procedures for IFSP development, review, and assessment must be in accordance with 34 CFR 303.342. ( )

a. Development of the IFSP. For a child who has been evaluated for the first time and has been determined to be eligible for DDA services, the initial IFSP developed by the Department must be completed within a forty-five (45) day time period in accordance with 34 CFR 303.321(e). ( )

b. Periodic Reviews. In cooperation with the child's service coordinator and other service providers, the DDA must participate in a review of the IFSP to be conducted every six (6) months, or more frequently, if conditions warrant or if the family requests such a review. The purpose of the periodic review is to identify progress made toward each objective and to determine whether these current outcomes and objectives need modification or revision. The review may be carried out in a meeting or by another means that is acceptable to the parent or legal guardian and other participants. These reviews must include the degree to which progress toward achieving the

outcomes is being made. ( )

i. The DDA must provide the child's service coordinator with any current assessments and other information from the ongoing assessment of the child to determine what services are needed and will be provided. ( )

ii. The DDA must identify outcomes and objectives for inclusion in the IFSP for any services to be provided through the DDA. ( )

c. Participants in the IFSP meetings and periodic reviews must be in accordance with 34 CFR 303.343. IFSP meetings and periodic reviews must include the parent or legal guardian, the service coordinator working with the family, persons providing direct services to the child and family as appropriate, and persons directly involved in conducting the assessments of the child. The family is encouraged to invite any family member, advocate, or friend to the meeting to assist in the planning process. ( )

d. The IFSP or IFSP addendum must be in accordance with 34 CFR 303.344, and include the following: ( )

i. A statement of the outcome; ( )

ii. Steps to support transitions; ( )

iii. Behaviorally-stated objectives toward meeting that outcome; ( )

iv. Frequency, intensity, and method of delivering a service to meet the outcome; ( )

v. Measurability criteria, strategies, and activities; ( )

vi. Start and end dates; ( )

vii. A description of the natural environments in which early intervention services are appropriately provided, including a justification of the extent, if any, to which services will not be provided in a natural environment; and ( )

viii. A list of who will be involved in the direct intervention. ( )

e. There must be an order by a physician or other practitioner of the healing arts for all DDA services included on the IFSP. ( )

f. Transition to preschool programs must be in accordance with 34 CFR 303.148. ( )

i. At the IFSP review closest to the child's second birthday, outcomes must be written to address the steps needed to ensure appropriate services for the child at age three (3). ( )

ii. At least six (6) months prior to the child's third birthday, the DDA must document contact with the child's service coordinator and participation in the transition planning process at the time of referral of the child to his local school district for IDEA, Part B, eligibility determination. ( )

04. Parental Consent and Right to Decline Service. Written parental consent must be obtained before: ( )

a. Conducting the assessment of a child; and ( )

b. Initiating the provision of services. ( )

05. Ongoing Assessment of the Child. The assessment of each child must: ( )

a. Be conducted by personnel trained to utilize appropriate methods and procedures; ( )

b. Be based on informed clinical opinion; and ( )

c. Include the following: ( )

i. A review of pertinent records related to the child's current health status and medical history. ( )

ii. An assessment of the child's level of functioning in cognitive development, physical development including vision and hearing, communication development, social or emotional development, and adaptive development. ( )

iii. An assessment of the unique needs of the child in terms of each of the developmental areas mentioned above in Subsection 654.05.c.ii. of this rule, including the identification of services appropriate to meet those needs. ( )

06. Services in the Natural Environment. Natural environments are settings that are natural or normal for the child's age peers who have no disability. To the maximum extent appropriate, in order to meet the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. ( )

07. Documentation of Program Changes. Documentation of required plan or Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other services providers, where applicable, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If there are changes to the Program Implementation Plan that affect the IFSP, an addendum to the IFSP must be completed: ( )

a. In cooperation with the service coordinator; ( )

b. With consent of the parent; ( )

c. With an order by the child's physician or other practitioner of the healing arts; ( )

d. With all changes documented on the enrollment form; and ( )

e. A copy of the addendum and the enrollment form must be submitted to the Department. ( )

655. DDA SERVICES: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: ( )

a. Comprehensive Developmental Assessment; ( )

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the twelve (12) hour limitation described in Subsection 655.01; ( )

c. Occupational Therapy Assessment; ( )

d. Physical Therapy Assessment; ( )

e. Speech and Language Assessment; ( )

f. Medical/Social History; and ( )

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. ( )

02. Comprehensive Assessments Conducted by the DDA. Assessments must be conducted by qualified professionals defined under Section 657 of these rules for the respective discipline or areas of service. ( )

a. Comprehensive Assessments. A comprehensive assessment must: ( )

i. Determine the necessity of the service; ( )

ii. Determine the participant's needs; ( )

iii. Guide treatment; ( )

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and ( )

v. For medical or psychiatric assessments, formulate a diagnosis. For psychological assessments, formulate a diagnosis and recommend the type of therapy necessary to address the participant's needs. For other types of assessments, recommend the type and amount of therapy necessary to address the participant's needs. ( )

b. Current Assessments Required. When the DDA determines developmental disabilities eligibility, current assessments must be completed or obtained as necessary. ( )

c. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. ( )

d. Assessment must be completed within forty-five (45) days. ( )

i. With the exception noted under Subsection 600.04.b. of this rule, each assessment must be completed within forty-five (45) calendar days of the date it was recommended by the physician or other practitioner of the healing arts. If the assessment is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. ( )

ii. This forty-five (45) day requirement does not apply to participant plans of service authorized under Sections 507 through 515 of these rules. ( )

03. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. ( )

a. Current Assessments for Ongoing Services. To be considered current, assessments must be completed or updated at least annually for service areas in which the participant is receiving services on an ongoing basis. ( )

b. Updated Assessments. Assessments or updates are required in disciplines in which services are being delivered and when recommended by a professional. At the time of the required review of the assessment(s), the qualified professional in the respective discipline must determine whether a full assessment or an updated assessment is required for the purpose of reflecting the participant's current status in that service area. If, during the required review of the assessment(s), the latest assessment accurately represents the status of the participant, the file must contain documentation from the professional stating so. ( )

c. Medical/Social Histories and Medical Assessments. Medical/social histories and medical assessments must be completed at a frequency determined by the recommendation of a professional qualified to conduct those assessments. ( )

d. Intelligence Quotient (IQ) Tests. Once initial eligibility has been established, annual assessment of IQ is not required for persons whose categorical eligibility for DDA services is based on a diagnosis of mental retardation. IQ testing must be reconducted on a frequency determined and documented by the agency psychologist or at the request of the Department. ( )

e. Completion of Assessments. Assessments must be completed or obtained prior to the delivery of therapy in each type of service. ( )

f. Psychological Assessment. A current psychological assessment must be completed or obtained: ( )

i. When the participant is receiving a behavior modifying drug(s); ( )

ii. Prior to the initiation of restrictive interventions to modify inappropriate behavior(s); ( )

iii. Prior to the initiation of supportive counseling; ( )

iv. When it is necessary to determine eligibility for services or establish a diagnosis; ( )

v. When a participant has been diagnosed with mental illness; or ( )

vi. When a child has been identified to have a severe emotional disturbance. ( )

04. Assessments for Adults. DDAs must obtain assessments required under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515 of these rules. All specific skill assessments must be conducted in accordance with Subsection 655.06 of these rules. ( )

05. Types of Comprehensive Assessments. ( )

a. Comprehensive Developmental Assessment. A comprehensive developmental assessment must be conducted by a qualified Development Specialist and reflect a person's developmental status in the following areas: ( )

i. Self-care; ( )

ii. Receptive and expressive language; ( )

iii. Learning; ( )

iv. Gross and fine motor development; ( )

v. Self-direction; ( )

vi. Capacity for independent living; and ( )

vii. Economic self-sufficiency. ( )

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. The requirements for the comprehensive IBI assessment are found under Subsection 656.03 of these rules. ( )

c. Occupational Therapy Assessment. Occupational therapy assessments must be conducted by an occupational therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. ( )

d. Physical Therapy Assessment. Physical therapy assessments must be conducted by a physical therapist qualified under Section 657 of these rules and include gross and fine motor abilities, and recommendation of therapy necessary to address the participant's needs. ( )

e. Speech and Language Assessment. Speech and language assessments must be conducted by a Speech-Language Pathologist who is qualified under Section 657 of these rules. ( )

f. Medical Assessments. Medical assessments must be completed by a physician or other practitioner of the healing arts who is qualified in accordance with Section 657 of these rules and accurately reflects the current status and needs of the person. ( )

g. Medical/Social History. Medical/social histories must be completed by a licensed social worker or other qualified professional working within the scope of his license. The medical/social history is a narrative report that must include: ( )

i. Medical history including age of onset of disability, prenatal and postnatal birth issues, other major medical issues, surgeries, and general current health information; ( )

ii. Developmental history including developmental milestones and developmental treatment interventions; ( )

iii. Personal history including social functioning/social relationships, recreational activities, hobbies, any legal and criminal history, and any history of abuse; ( )

iv. Family history including information about living or deceased parents and siblings, family medical history, relevant family cultural background, resources in the family for the participant; ( )

v. Educational history including any participation in special education; ( )

vi. Prevocational or vocational paid and unpaid work experiences; ( )

vii. Financial resources; and ( )

viii. Recommendation of services necessary to address the participant's needs. ( )

h. Hearing Assessment. A hearing assessment must be conducted by an audiologist who is qualified under Section 657 of these rules. ( )

i. Psychological Assessment. A psychological assessment includes psychological testing for diagnosis and assessment of personality, psychopathology, emotionality, or intellectual abilities (IQ test). The assessment must include a narrative report. Psychological assessment encompasses psychological testing and the psychiatric diagnostic interview. ( )

j. Psychological Testing. Psychological testing refers to any measurement procedure for assessing psychological characteristics in which a sample of a person’s behavior is obtained and subsequently evaluated and scored using a standardized process. This does not refer to assessments that are otherwise conducted by a professional within the scope of his license for the purposes of determining a participant's mental status, diagnoses, or functional impairments. ( )

i. Psychological testing may be provided when in direct response to a specific assessment question. ( )

ii. The psychological report must contain the reason for the performance of this service. ( )

iii. Agency staff may deliver this service if they meet one (1) of the following qualifications: ( )

(1) Licensed Psychologist; ( )

(2) Psychologist Extender; or ( )

(3) A qualified therapist listed in Subsection 651.03.e. of these rules who has documented evidence of education or training qualifying him to administer, score, interpret, and report findings for the psychological test he will be performing. ( )

k. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must be conducted in accordance with Subsection 651.09 of these rules. ( )

06. Requirements for Specific Skill Assessments. Specific skill assessments must: ( )

a. Further Assessment. Further assess an area of limitation or deficit identified on a comprehensive assessment. ( )

b. Related to a Goal. Be related to a goal on the IPP, ISP, or IFSP. ( )

c. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective disciplines as defined in this chapter. ( )

d. Determine a Participant's Skill Level. Be conducted for the purposes of determining a participant's skill level within a specific domain. ( )

e. Determine Baselines. Be used to determine baselines and develop the program implementation plan. ( )

07. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. ( )

a. General Requirements for Program Documentation. For each participant the following program documentation is required: ( )

i. Daily entry of all activities conducted toward meeting participant objectives. ( )

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and ( )

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. ( )

iv. When a participant receives developmental therapy, documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. ( )

b. Additional Requirements for Participants Eighteen Years or Older. For participant's eighteen (18) years of age or older, DDAs must also submit provider status reviews to the plan monitor in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. ( )

c. Additional Requirements for Participants Seven Through Sixteen. For participants ages seven (7) through sixteen (16), the DDA must also document that the child has been referred to the local school district in accordance with the collaboration requirements in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

d. Additional Requirements for Participants Birth to Three Years of Age. For participants birth to age three (3), the following are required in addition to those requirements in Subsection 654.01 of these rules: ( )

i. Documentation of the six (6) month and annual reviews; ( )

ii. Documentation of participation in transition planning at the IFSP developed closest to the child's second birthday to ensure service continuity and access to community services as early intervention services end at age three (3); ( )

iii. Documentation that participant rights have been met in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

iv. Documentation of participation in the transition meeting with the school district; and ( )

v. Documentation of consultation with other service providers who are identified on the IFSP. ( )

08. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be written and implemented within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. The Program Implementation Plan must include the following requirements in Subsections 655.08.a. through 655.08.g. of this rule: ( )

a. Name. The participant's name. ( )

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. ( )

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. ( )

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. ( )

e. Service Environments. Identification of the type of environment(s) where services will be provided. ( )

f. Target Date. Target date for completion. ( )

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. ( )

656. REQUIREMENTS FOR THE DELIVERY OF INTENSIVE BEHAVIORAL INTERVENTION (IBI).

01. Individualized and Comprehensive Interventions. IBI consists of individualized, comprehensive interventions that have been shown to be effective and are used on a short term, one-to-one basis. These interventions: ( )

a. Produce measurable outcomes that diminish behaviors that interfere with the development and use of language and appropriate social interaction skills; or ( )

b. Broaden an otherwise severely restricted range of interest; and ( )

c. Increase the child's ability to participate in other therapies and environments. ( )

02. IBI Authorization and Review. IBI services must be reviewed and prior authorized for each service year as follows: ( )

a. Initial IBI Authorization. The Department determines IBI eligibility based on information submitted by the DDA and other information gathered by the Department as deemed necessary. At least twenty (20) working days prior to the intended start date of IBI services, the DDA must use Department-approved forms to submit; ( )

i. Evidence of the child's eligibility for Intensive Behavioral Intervention; ( )

ii. The comprehensive IBI assessments; ( )

iii. The Program Implementation Plans; ( )

iv. The number of hours of service requested; and ( )

v. Measurable objectives. ( )

b. Three- (3) Month Review. The agency must conduct and document a formal review of therapy objectives and direction for future therapy for each objective. ( )

c. Six- (6) Month Review and Authorization. At least fifteen (15) working days prior to the expiration of prior authorized IBI services the agency must submit: ( )

i. The three- (3) month review; ( )

ii. Documentation of the child’s progress on IBI goals and outcomes of the IBI objectives for those six (6) months; and ( )

iii. When continuing IBI services are requested, the Program Implementation Plans, the number of hours of service requested, and the measurable objectives, using Department-approved forms. Continued services will not be authorized when little or no progress has been documented and justification is inadequate to continue IBI services. ( )

d. Nine- (9) Month Review. The agency must conduct and document a formal review of therapy objectives and direction for future therapy for each objective. ( )

e. Annual Review and Authorization. At least fifteen (15) working days prior to the expiration of prior authorized IBI services the agency must submit: ( )

i. The nine- (9) month review; ( )

ii. Documentation of the child’s progress on IBI goals and outcomes of the IBI objectives for that year; and ( )

iii. When continuing IBI services are requested: ( )

(1) A new SIB-R that reflects the child’s current status and any additional information required to establish continuing eligibility; ( )

(2) The Program Implementation Plans; and ( )

(3) The number of hours of service requested and the measurable objectives, using Department-

approved forms. Continued services will not be authorized when little or no progress has been documented and justification is inadequate to continue IBI services. ( )

03. Comprehensive IBI Assessment. A comprehensive IBI assessment must be completed by a certified IBI professional prior to the initial provision of IBI or IBI Consultation. The results of the assessment must form the basis for planning interventions. The assessment must include the following: ( )

a. Review of Assessments and Relevant Histories. ( )

i. Medical history, medications, and current medical status; ( )

ii. Medical/social history that includes a developmental history and onset of developmental disability; ( )

iii. Comprehensive developmental assessment reflecting the child's current status; ( )

iv. Specific skill assessment, when such an assessment is completed; ( )

v. SIB-R Maladaptive Index and a list of the child's maladaptive behaviors; ( )

vi. Baseline of the child's maladaptive behavior(s), if available; ( )

vii. Psychological assessments and results of psychometric testing, or for very young children, a developmental assessment with equivalent age-appropriate social-emotional status, if available; ( )

viii. A mental health or social and emotional assessment, such as the Child and Adolescent Functional Assessment Scale (CAFAS), when one has been completed; ( )

ix. Public school or Infant Toddler Program records including relevant birth records, multidisciplinary team assessments, recommendations, and Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs); and ( )

x. Other relevant assessments that may be available, including those for speech and hearing and physical and occupational therapy. ( )

b. Interviews. Interviews must be conducted with the child, if possible, and to the extent of the child's abilities; the child's parent or legal guardian, or the primary care provider; and any other individuals who spend significant amounts of time with the child. These interviews must result in a written summary of the findings of each interview and include the following: ( )

i. Description of the child's desired and problem behaviors; ( )

ii. Opinion about environmental stimuli that appear to precede problem behaviors; ( )

iii. Opinion about the internal states or setting events that precede desired and problem behaviors; ( )

iv. Opinion about identification of stimuli that maintain the desired or problem behaviors; and ( )

v. Opinion about factors that alleviate problem behaviors and increase desired behaviors. ( )

c. Observation of the Child. Observations of the child must occur in environments in which the child spends significant amounts of time and where problem behaviors have been reported. Results of the observations must include the following: ( )

i. Specific descriptions and frequencies of problem behaviors; ( )

ii. Identification of environmental stimuli that appear to precede problem behaviors; ( )

iii. Identification of internal states or setting events that appear to precede problem behaviors; ( )

iv. Identification of stimuli that maintain the desired or problem behaviors; and ( )

v. Identification of factors that alleviate problem behaviors and increase desired behaviors. ( )

d. Clinical Opinion. Clinical opinion about the underlying causes, antecedents, motivations, and communicative intent of desired and problem behaviors. ( )

04. IBI Program Implementation Plans Requirements. In addition to the requirements under Subsections 655.08.a. through 655.08.g. of these rules, the following are also required for IBI Implementation Plans: ( )

a. All IBI Implementation Plans must be completed on the Department-approved form. ( )

b. On all IBI Implementation Plan cover sheets, the signature of a parent or legal guardian is required. If the signatures of the parent or legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. ( )

05. IBI Transition Plan. An IBI transition plan must be developed when it is anticipated that IBI services will be terminated within the next Department or agency review period and the child will be moving into natural learning environments or less intensive therapy settings. The IBI transition plan may not be used as a substitute for, nor does it replace the transition plans required under Sections 653 and 654 of these rules. IBI transition plans must include the following steps to support the transition and the timelines for those steps: ( )

a. Setting. The setting to which the child will be moving and the therapists or persons who will be interacting with the child; and ( )

b. Training of New Therapists or Other Persons. How behavioral intervention techniques will be shared with new therapists or other persons in the new environments to encourage generalization and maintenance of appropriate behavior and action to be taken if the child demonstrates regression in the new setting in skills learned through IBI. ( )

06. IBI Consultation. Professionals may provide IBI consultation to parents and other family members, professionals, paraprofessionals, school personnel, child care providers, or other caregivers who provide therapy or care for an IBI eligible child in other disciplines to ensure successful integration and transition from IBI to other therapies, services, or types of care. IBI consultation objectives and methods of measurement must be developed in collaboration with the person receiving IBI consultation. ( )

a. Service Delivery Qualification. IBI consultation must be delivered by an IBI professional who meets the requirements in Section 657 of these rules. ( )

b. Measurable Progress. IBI consultation must result in measurable improvement in the child's behavior. It is not intended to be used for educational purposes only. ( )

c. Evidence of Progress. Persons who receive IBI consultation must meet with the IBI professional, agree to follow an IBI Implementation Plan, and provide evidence of progress. ( )

d. Individualized. IBI consultation may not be reimbursed when it is delivered to a group of parents. IBI consultation is specific to the unique circumstances of each child. ( )

657. DDA SERVICES: DDA PROVIDER QUALIFICATIONS AND DUTIES.

01. Audiologist, Licensed. A person licensed to conduct hearing assessment and therapy, in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who either

possesses a certificate of clinical competence in audiology from the American Speech, Language and Hearing Association (ASHA) or will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification. ( )

02. Counselor, Licensed Clinical Professional. A person licensed to practice as a clinical professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

03. Counselor, Licensed Professional. A person licensed to practice as a professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

04. Marriage and Family Therapist. ( )

a. Licensed Marriage and Family Therapist. A person licensed to practice as a marriage and family therapist in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

b. Registered Marriage and Family Therapist Intern. A person registered to practice as a marriage and family therapist intern under the direct supervision of a Licensed Marriage and Family Therapist, in accordance with Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." ( )

05. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: ( )

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or ( )

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 420.05.a. of this rule and have: ( )

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and ( )

ii. Passed a competency examination approved by the Department. ( )

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. ( )

06. Developmental Specialist for Children Three Through Seventeen. A Developmental Specialist providing developmental assessment and therapy services to children ages three (3) through seventeen (17) must meet the requirements for a Developmental Specialist for adults, and must also meet the following requirements: ( )

a. Successfully complete a competency course approved by the Department that relates to developmental assessment and therapy for children; and ( )

b. Pass a competency examination approved by the Department. ( )

07. Developmental Therapy Paraprofessionals Delivering Services to Participants Age Three and Older. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children age (3) and older if they are under the supervision of a Developmental Specialist. A

developmental therapy paraprofessional must be at least seventeen (17) years of age. ( )

08. Developmental Specialist for Children Birth to Three. ( )

a. To provide developmental assessments and therapy to children birth to three (3) years of age, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: ( )

i. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or ( )

ii. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; ( )

iii. A bachelor's or masters degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: ( )

(1) Promotion of development and learning for children from birth to three (3) years; ( )

(2) Assessment and observation methods for developmentally appropriate assessment of young children; ( )

(3) Building family and community relationships to support early interventions; ( )

(4) Development of appropriate curriculum for young children, including IFSP and IEP development; ( )

(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and ( )

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. ( )

b. Electives closely related to the content under Subsection 420.08.a.iii. may be approved by the Department with a recommendation from an institution of higher education. ( )

c. A developmental specialist who possesses a bachelor's or master's degree listed above under Subsection 420.08.a.ii. of this rule, must have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with his approved, conditional hiring agreement. ( )

d. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: ( )

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. ( )

ii. Satisfactory progress will be determined on an annual review by the Department. ( )

iii. An individual who has an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as he demonstrates satisfactory progress on the plan and complete the requirements on the plan within three (3) years of his date of hire. ( )

09. Developmental Therapy Paraprofessionals Delivering Services to Children Birth to Three. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children birth to three (3) years of age if they are under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. Developmental therapy paraprofessionals serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: ( )

a. Be at least eighteen (18) years of age; ( )

b. Be a high school graduate or have a GED; and ( )

c. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education or closely-related coursework; or ( )

d. Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist. ( )

10. Intensive Behavioral Intervention (IBI) Professional Delivering Services to Participants Three to Twenty-One. A person qualified to provide or direct the provision of Intensive Behavioral Intervention (IBI) must meet the following requirements: ( )

a. Degree. A qualified IBI professional must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college. ( )

b. Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. The year's experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. ( )

c. Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under Section 415 of these rules. ( )

11. IBI Paraprofessionals Delivering Services to Participants Three to Twenty-One. A certified IBI paraprofessional may be used to provide IBI under the supervision of a certified IBI professional and must comply with Section 405 of these rules. An IBI paraprofessional must also: ( )

a. Be at least eighteen (18) years of age; ( )

b. Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year of supervised experience working with children with developmental disabilities. The year of experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. ( )

c. Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under Section 415 of these rules. ( )

12. IBI Professionals Delivering Services to Children Birth to Three. A person qualified to provide or direct the provision of IBI to children under three (3) years of age must meet the staff qualifications described under Subsections 420.08.a.ii. through 420.08.d. and 420.10.b. through 420.10.d. of these rules and the certification and training requirements above under Subsections 415.03 and 415.04 of these rules. ( )

13. IBI Paraprofessionals Delivering Services to Children Birth to Three. A paraprofessional serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: ( )

a. Be at least eighteen (18) years of age; ( )

b. Be a high school graduate or have a GED; and ( )

c. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) credits in child development, special education, or closely-related coursework; or ( )

d. Have three (3) years of documented experience providing care to infants, toddlers or children under five (5) years of age under the supervision of a child development professional, certified educator, or licensed therapist or Developmental Specialist. ( )

e. Qualified IBI professionals and paraprofessionals must comply with the requirements under Section 415 of these rules. ( )

14. Nurse Practitioner. A licensed professional nurse (RN) who has met all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

15. Occupational Therapist. A person qualified to conduct occupational therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." ( )

16. Physical Therapist. A person qualified to conduct physical therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.05, "Licensure of Physical Therapists Idaho State Board of Medicine and Physical Therapist Assistants." ( )

17. Physician. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code. ( )

18. Physician Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: ( )

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or ( )

b. Has satisfactorily completed a program for preparing physician's assistants that: ( )

i. Was at least one (1) academic year in length; and ( )

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and ( )

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. ( )

19. Psychiatric Nurse, Certified. A licensed professional nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. ( )

20. Psychiatrist. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code, and who meets the requirements for certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. ( )

21. Psychologist. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho

Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ( )

22. **Psychologist Extender**. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. ( )

23. **Social Worker, Licensed**. A person licensed in accordance with the Social Work Licensing Act, Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

24. **Masters Social Worker, Licensed**. A person who is licensed as a masters social worker (LMSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

25. **Clinical Social Worker, Licensed**. A person who is licensed as a clinical social worker (LCSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

26. **Speech-Language Pathologist, Licensed**. A person licensed to conduct speech-language assessment and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification. ( )

658. GENERAL STAFFING REQUIREMENTS FOR AGENCIES.

01. **Standards for Paraprofessionals Providing Developmental Therapy and IBI**. When a paraprofessional provides either developmental therapy or IBI, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under Section 415 of these rules and must meet the qualifications under Section 420 of these rules. A paraprofessional providing IBI must be supervised by an IBI professional; a paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. Paraprofessionals providing developmental therapy to children birth to three (3) years of age must work under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. For paraprofessionals to provide developmental therapy or IBI in a DDA, the agency must adhere to the following standards: ( )

a. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service, develop a Program Implementation Plan, or conduct collateral contact or IBI consultation. These activities must be conducted by a professional qualified to provide the service. ( )

b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under his supervision, on a weekly basis or more often if necessary: ( )

i. Give instructions; ( )

ii. Review progress; and ( )

iii. Provide training on the program(s) and procedures to be followed. ( )

c. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under his supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). ( )

d. Limitations to Service Provision by an IBI Paraprofessional. IBI provided by a paraprofessional is limited to ninety percent (90%) of the direct intervention time, per individual participant. The remaining ten percent

(10%) of the direct intervention time must be provided by the professional qualified to provide and direct the provision of IBI. ( )

e. Additional Training Requirements for IBI Professionals and IBI Paraprofessionals. Qualified IBI professionals and IBI paraprofessionals must complete and pass a Department-approved training course and examination for certification. The training must include a curriculum that addresses standards of competence for the provision of IBI and ethical standards. Specifically, the curriculum must include: ( )

i. Assessment of individuals; ( )

ii. Behavioral management; ( )

iii. Services or treatment of individuals; ( )

iv. Supervised practical experience; and ( )

v. Successful completion of a student project that includes an observation of demonstrated competencies for all individuals applying for initial certification or recertification after July 1, 2003. ( )

f. Continuing Training Requirements for IBI Professionals and IBI Paraprofessionals. Each IBI professional and IBI paraprofessional, in order to maintain certification, must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. ( )

i. The initial IBI certification training meets the yearly training requirement for the calendar year in which the IBI professional or paraprofessional was first certified. ( )

ii. If the individual has not completed the required training during any yearly training period, he may not provide IBI services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. ( )

iii. An individual may remain IBI certified, despite being unable to bill for services, through two (2) consecutive annual training periods during which that individual has deficient training hours. A DDA may begin billing for the certified IBI Professional or Paraprofessional again after the required training hours are accumulated. ( )

iv. If an individual completes three (3) consecutive annual training periods without having accumulated sufficient training to satisfy the training requirement for the first of those periods, that individual's IBI certification is automatically rescinded and will no longer be recognized. To be recertified, the individual must retake the state IBI exam and complete the IBI Student Project, if not previously completed. ( )

02. General Staffing Requirements for Agencies. ( )

a. Administrative Staffing. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. ( )

i. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and ( )

ii. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with

developmental disabilities. ( )

b. Other required staffing. The agency must have available, at a minimum, the following personnel, qualified in accordance with Section 657 of these rules, as employees of the agency or through formal written agreement: ( )

i. Speech-language pathologist or audiologist; ( )

ii. Developmental Specialist; ( )

iii. Occupational therapist; ( )

iv. Physical therapist; ( )

v. Psychologist; and ( )

vi. Social worker, or other professional qualified to provide the required services under the scope of his license. ( )

65~~6~~9. DDA SERVICES: PROVIDER REIMBURSEMENT.
Payment for agency services must be in accordance with rates established by the Department. (3-19-07)

657. 699. (RESERVED).

CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION (Sections 660 through 669)

660. CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.
In accordance with 1915i of the Social Security Act, the Department will pay for home and community based services provided by individuals or agencies that have entered into a provider agreement with the Department. Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. ( )

661. CHILDREN'S HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Action Plan. An initial or annual plan of service developed by the plan developer for providing developmental disability services to children from birth through seventeen (17) years of age. ( )

02. Agency. A developmental disabilities agency (DDA) as defined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

03. Annual. Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. ( )

04. Community. Natural, integrated environments outside of the home, school, or DDA center-based settings. ( )

05. Developmental Disabilities Agency (DDA). A DDA is an agency that is: ( )

a. A type of developmental disabilities facility, as defined in Section 39-4604(7), Idaho Code, that is non-residential and provides services on an outpatient basis; ( )

b. Certified by the Department to provide home and community based services to people with developmental disabilities, in accordance with these rules; ( )

c. A business entity, open for business to the general public; and ( )

d. Primarily organized and operated to provide home and community based services and the corresponding assessments to people with developmental disabilities. DDA services include evaluations, diagnostic, treatment, and support services that are provided on an outpatient basis to persons with developmental disabilities and may be community-based, home-based, or center-based in accordance with the requirements of this chapter. ( )

06. Clinical Supervisor. The professional responsible for the supervision of DDA staff as outlined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

07. Family-Centered Planning Process. A process facilitated by the plan developer, comprised of the child participant (unless otherwise determined by the family-centered planning team), parent or legal guardian, and individuals significant to the participant who collaborate with the participant to develop the plan of service. ( )

08. Family-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the parent or legal guardian and the plan developer. The family-centered planning team may include others identified by the family or agreed upon by the family and the Department as important to the process. ( )

09. Home and Community Based Services State Plan Option. The federal authority under section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and individuals with disabilities, without determining that without the provision of services the individuals would require institutional level of care. ( )

10. Individualized Family Service Plan (IFSP). An initial or annual plan of service, developed by the Department or its designee, for providing early intervention services to children birth to age three (3). This plan must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C. The IFSP may serve as the action plan when meeting all of the components of the action plan. ( )

11. Integration. The process of promoting a life for individuals with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of individuals with developmental disabilities. ( )

12. Natural Environments. Settings that are typical for peers of a relative age. The environment where the activity or behavior naturally occurs, such as the community where they live and according to the service environment indicated. ( )

13. Paraprofessional. A paraprofessional provides direct support services which include respite and habilitative supports. ( )

14. Plan Developer. A paid or nonpaid person identified by the participant who is responsible for developing a service plan and subsequent addenda that covers all services and supports, based on a family-centered planning process. The plan developer acts as the plan monitor by overseeing the provision of services on the plan of service on a paid or non-paid basis. ( )

15. Plan of Service. An initial or annual plan that identifies services and supports. Plans are developed annually. In this chapter of rules, "plan of service" refers to the Action Plan or IFSP. ( )

16. Prior Authorization (PA). A process for determining a child's eligibility for services and medical necessity prior to the delivery or payment of services in accordance with Sections 520 through 528 of these rules.

( )

17. **Professional**. A professional provides direct intervention services which include habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. ( )

18. **Support Services**. Support services are provided by a paraprofessional, or technician level staff, working under the supervision of an agency professional. Support services may provide supervision for a participant, as well as may provide assistance to a participant by facilitating integration into the community. ( )

662. CHILDREN'S HCBS STATE PLAN OPTION: PARTICIPANT ELIGIBILITY.
Children's Home and Community Based State Plan Option eligibility will be determined by the Department as described in Section 520 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787 and Section 1915(i) of the Social Security Act. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, participants must meet the following requirements: ( )

01. **Age of Participants**. Participants eligible to receive children's HCBS must be birth through seventeen (17) years of age. ( )

02. **Eligibility Determinations**. The Department must determine that prior to receiving children's HCBS state plan option services, an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, and have a demonstrated need for Children's HCBS state plan option services. ( )

663. CHILDREN'S HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
All children's home and community based services must be identified on a plan of service developed by the family-centered planning team, including the plan developer. The following services are reimbursable when provided in accordance with these rules: ( )

01. **Respite**. Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a DDA, or in the community. Payment for respite services are not made for room and board. ( )

a. Respite must only be offered to participants living with an unpaid caregiver who requires relief. ( )

b. Respite must not be provided at the same time other Medicaid services are being provided. ( )

c. Respite must not be provided on a continuous, long-term basis where it is part of daily services that would enable an unpaid caregiver to work. ( )

d. When respite is provided as group respite, the following applies: ( )

i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every six (6) participants. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. ( )

ii. When group respite is home and community-based, there must be a minimum of one (1) qualified staff providing direct services to every three (3) participants. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. ( )

02. **Habilitative Supports**. Habilitative Supports provides assistance to a participant with a disability by facilitating the participant's independence and integration into the community. This service provides an

opportunity for participants to explore their interests and improve their skills by participating in natural environments. Habilitative Supports is not active treatment. Instead, the participant learns through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization and relationship building, and participation in leisure and community activities. Habilitative Supports must: ( )

a. Only be provided in community settings and have integration into the community as an identified goal on the plan of service; ( )

b. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; ( )

c. Ensure the participant is actively participating in age appropriate activities and is engaging with typical peers; and ( )

d. Have a minimum of one (1) qualified staff providing direct services to every three (3) participants when provided as group habilitative supports. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. ( )

03. Family Education. Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent or legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. ( )

a. Family education may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the participant. ( )

b. The family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. ( )

c. Family education may be provided in a group setting not to exceed ten (10) individuals. ( )

04. Family-Directed Community Supports. Participants eligible for the children's home and community based state plan option may choose to family-direct their individualized budget rather than receive the traditional services described in this Section of rule. The requirements for this option are outlined in IDAPA 16.03.13 "Consumer-Directed Services." ( )

05. Supervision. Clinical supervisor(s) are professionals employed by a DDA on a continuous and regularly scheduled basis. ( )

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. ( )

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. ( )

c. Each DDA must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. ( )

06. Limitations. ( )

a. HCBS state plan option services are subject to the participant's individualized budget. ( )

b. HCBS state plan option services cannot be used to pay for special education and related services

that are included in a child's Individual Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). The funding of such services is the responsibility of state and local education agencies. 1903(c)(3) of the Social Security Act provides that federal financial participation (FFP) is available for service included in an IEP when such services are furnished as basic Medicaid benefits. HCBS state plan option services are not considered to be basic Medicaid benefits. ( )

c. For the children's HCBS state plan option services listed in Subsections 663.01 and 663.02, the following are excluded for Medicaid payment: ( )

i. Vocational services; and ( )

ii. Educational services. ( )

664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. General Requirements for Program Documentation. The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following program documentation is required: ( )

a. Direct service provider information which includes written documentation of each visit made or service provided to the participant, and contains, at a minimum, the following information: ( )

i. Date and time of visit; and ( )

ii. Intervention and support services provided during the visit; and ( )

iii. A statement of the participant's response to the service including any changes in the participant's condition; and ( )

iv. Length of visit, including time in and time out; and ( )

v. Specific place of service. ( )

vi. A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ( )

02. Habilitative Supports Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the following must be completed: ( )

a. Monthly Summary. On a monthly basis, the habilitative support staff must complete a narrative summary of the participant's response to the support service and submit the monthly summary to the clinical supervisor. ( )

b. Review and Recommendations. The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the plan developer. ( )

03. Family Education Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the DDA must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. ( )

04. Reporting Requirements. The clinical supervisor must complete at a minimum, six- (6) month and annual reviews for services provided at a frequency determined on the plan of service. Documentation of the six-(6) month and annual reviews must be submitted to the plan developer. ( )

665. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.

All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. ( )

01. **Respite**. Respite services may be provided by an agency that is certified as a DDA under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," and is capable of supervising the direct services provided, or by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite services must meet the following minimum qualifications: ( )

a. Must be at least sixteen (16) years of age when employed by a DDA; or ( )

b. Must be at least eighteen (18) years of age and be a high school graduate or have a GED to act as an independent respite provider; and ( )

c. Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the waiver participant, the family, or the participant's guardian; ( )

d. Have received care-giving instructions in the needs of the participant who will be provided the service; ( )

e. Demonstrate the ability to provide services according to a plan of service; ( )

f. Have good communication and interpersonal skills and the ability to deal effectively, assertively, and cooperatively with a variety of people; ( )

g. Be willing to accept training and supervision; ( )

h. Be free of communicable diseases; and ( )

i. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks." ( )

02. **Habilitative Support Staff**. Habilitative supports must be provided by an agency certified as a DDA under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," with staff who are capable of supervising the direct services provided. Providers of habilitative supports must meet the following minimum qualifications: ( )

a. Must be at least eighteen (18) years of age; ( )

b. Must be a high school graduate or have a GED; ( )

c. Demonstrate the ability to provide services according to a plan of service; ( )

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively, and cooperatively with a variety of people; ( )

e. Be willing to accept training and supervision; ( )

f. Be free of communicable diseases; ( )

g. Demonstrate knowledge of infection control methods; ( )

h. Agree to practice confidentiality in handling situations that involve participants; ( )

i. Habilitative Supports providers who provide direct care and services must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks";

( )

j. Experience. The individual must have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: ( )

i. Previous work experience. Experience gained through paid employment or university practicum experience or internship; or ( )

ii. On the job supervised experience. Experience gained through employment at a DDA with increased supervision. Increased supervision includes, but is not limited to, six (6) hours of job shadowing prior to delivery of direct support services, and a minimum of weekly face-to-face supervision with the clinical supervisor for a period of six (6) months. ( )

k. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports. ( )

03. Family Education. Family education must be provided by an agency certified as a DDA under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," with staff who are capable of supervising the direct services provided. Providers of family education must meet the following minimum qualifications: ( )

a. Must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college and has: ( )

i. One (1) year experience providing care to children with developmental disabilities; ( )

ii. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; and ( )

iii. Must complete a supervised practicum; or ( )

b. Individuals certified as Developmental Specialists for children ages birth through three (3) or three (3) through seventeen (17), and individuals certified as Intensive Behavioral Interventionists prior to July 1, 2011, are qualified to provide family education until June 30, 2013. Prior to June 30, 2013, the individual must meet the requirements of the Department-approved competency coursework. ( )

04. Requirements for Clinical Supervisor. All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications of a habilitative interventionist as defined in Section 685 of these rules. ( )

05. Requirements for Collaboration. Providers of home and community based services must coordinate regularly with the family-centered planning team as specified on the plan of service. ( )

06. Requirements for Quality Assurance. Providers of children's home and community based state plan option services must demonstrate high quality of services through an internal quality assurance review process. ( )

07. DDA Services. In order for a DDA to provide respite, habilitative supports, and family education the DDA must be certified to provide support services. Each DDA is required to provide habilitative supports. In addition, the DDA may also opt to provide respite, habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. ( )

666. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER REIMBURSEMENT.

01. Fee-for-Service. Children's HCBS State Plan Option service providers will be paid on a fee-for-service basis, based on the type of service provided as established by the Department. ( )

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved

by the Department. Billing instructions will be provided by the Department. ( )

03. Rates. The reimbursement rates calculated for children's HCBS include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation.( )

667. -- 679. (RESERVED).

CHILDREN'S WAIVER SERVICES
(Sections 680 through 699)

680. CHILDREN'S WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. ( )

681. CHILDREN'S WAIVER SERVICES: DEFINITIONS.
Definitions in Section 661 of the rules apply. Additionally, the following definitions apply to children's waiver services: ( )

01. Baseline. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. ( )

02. Crisis. An unanticipated event, circumstance, or life situation that places a participant at risk of at least one of the following: ( )

a. Hospitalization; ( )

b. Loss of housing; ( )

c. Loss of employment; ( )

d. Incarceration; or ( )

e. Physical harm to self or others, including family altercation or psychiatric relapse. ( )

03. Intervention Services. Intervention services are outcome-based, therapeutic services delivered by a professional working under the supervision of the agency delivering the intervention services. ( )

04. Objective. A behavioral outcome statement developed to address a particular need identified for a participant. An objective is written in measurable terms that specify a target date for completion, no longer than one (1) year in duration, and include criteria for successful attainment of the objective. ( )

05. Probe. A probe is data gathered on an intermittent basis, after a baseline is established, to measure a participant's level of independent performance as related to an identified objective. ( )

06. Program Implementation Plan. A plan that details how intervention goals from the plan of service will be accomplished. ( )

07. Specific Skill Assessment. A type of assessment used to determine the baseline or the need for further supports or intervention for the discipline area being assessed. ( )

08. Provider Status Review. The written documentation that identifies a participant's progress toward

goals defined in the plan of service. ( )

682. CHILDREN'S WAIVER SERVICES: ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 522 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following requirements: ( )

01. Age of Participants. The following waiver programs are available for children: ( )

a. Children's DD Waiver. Children's DD waiver participants must be birth through seventeen (17) years of age. ( )

b. Act Early Waiver. Act Early waiver participants must be three (3) through six (6) years of age. ( )

02. Eligibility Determinations. The Department must determine that: ( )

a. The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 683 of these rules were not made available; and ( )

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. ( )

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs. ( )

d. Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. ( )

03. Additional Act Early Waiver Requirements. In addition to the requirements listed in Subsections 682.01 and 682.02 of this rule, a participant must have the following characteristics to qualify for Act Early waiver services: ( )

a. An autism spectrum diagnosis; or ( )

b. Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified by the Department and a severe deficit, defined as having a composite full scale functional age equivalency of fifty percent (50%) or less of the participant's chronological age. ( )

04. Children's Waiver Eligible Participants. A participant who is determined by the Department to be eligible for services under the children's waivers may elect not to utilize waiver services, but may choose admission to an ICF/ID. ( )

05. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the children's waivers for participants with developmental disabilities will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after June 30th of each new waiver year. ( )

683. CHILDREN'S WAIVER SERVICES: COVERAGE AND LIMITATIONS.

All children's DD waiver services must be identified on a plan of service developed by the family-centered planning team, including the plan developer. In addition to the children's home and community based state plan option services described in Section 663 of these rules, the following services are available for waiver eligible participants and are reimbursable services when provided in accordance with these rules: ( )

01. Family Training. Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services. ( )

a. Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service. ( )

b. Family training must be provided to the participant's parent or legal guardian when the participant is present. ( )

c. The family training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. ( )

d. The parent or legal guardian of the waiver participant is required to participate in family training when the participant is receiving habilitative interventions. The following applies for each waiver program: ( )

i. For participants enrolled in the Children's DD Waiver, the amount, duration, and frequency of the training must be determined by the family-centered planning team and the parent or legal guardian, and must be listed as a service on the plan of service. ( )

ii. For participants enrolled in the Act Early Waiver, the parent or legal guardian will be required to be present and actively participate during the intervention service session for at least twenty percent (20%) of the intervention time provided to the child. ( )

02. Interdisciplinary Training. Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the waiver participant. ( )

a. Interdisciplinary training includes: ( )

i. Health and medication monitoring; ( )

ii. Positioning and transfer; ( )

iii. Intervention techniques; ( )

iv. Positive Behavior Support; ( )

v. Use of equipment; ( )

b. Interdisciplinary training must only be provided to the direct service provider when the participant is present. ( )

c. The interdisciplinary training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. ( )

d. Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service. ( )

e. Interdisciplinary training between employees of the same discipline is not a reimbursable service. ( )

03. **Habilitative Intervention Evaluation**. The purpose of the habilitative intervention evaluation is to guide the development of objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include: ( )

a. Specific skills assessments for deficit areas identified through the eligibility assessment; ( )

b. Functional behavioral assessment; ( )

c. Review of all assessments and relevant histories provided by the plan developer; and ( )

d. Clinical Opinion. Professional summary that interprets and integrates the results of the testing. This summary includes functional, developmentally appropriate recommendations to guide treatment. ( )

04. **Habilitative Intervention**. Habilitative intervention services must be consistent, aggressive, and continuous and are provided to improve a child's competencies and discourage problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. As "promising practices" meet statistically significant effectiveness, they could be included as approved approaches. ( )

a. Habilitative intervention must be provided to address at least one (1) of the following areas: ( )

i. Diminish Maladaptive Behaviors. When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation. ( )

ii. Develop Adaptive Skills. When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional. ( )

b. Settings. Habilitative intervention must be provided in the participant's home or community setting, and in addition may be provided in a center-based setting. ( )

c. Group Interventions. When habilitative intervention is provided as group intervention, the following applies: ( )

i. There must be a minimum of one (1) qualified staff providing direct services for every three (3) participants. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. ( )

ii. When group intervention is community-based, the child must be integrated in the community in a natural setting with typically developing peers. ( )

iii. Group intervention must be directly related to meeting the needs of the child, and be identified as an objective in accordance with a plan of service goal. ( )

05. **Therapeutic Consultation**. Therapeutic consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more sophisticated level of training and assistance based on the participant's complex needs. A participant requires therapeutic consultation when current best practice interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service. The therapeutic consultant assists the habilitative interventionist by: ( )

a. Performing advanced assessments; ( )

b. Developing and overseeing the implementation of a positive behavior support plan; ( )

c. Monitoring the progress and coordinating the implementation of the plan across environments; and ( )

d. Providing consultation to other service providers and families. ( )

e. Therapeutic Consultation Services Limitations. Therapeutic consultation providers are subject to the following limitations: ( )

i. Therapeutic consultation cannot be provided as a direct intervention service. ( )

ii. Participants must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations authorized by the Department. ( )

iii. Therapeutic consultation is limited to twelve (12) hours per year per participant. ( )

iv. Therapeutic consultation must be prior authorized by the Department. ( )

06. Crisis Intervention. Crisis intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. The need for crisis intervention must meet the definition of crisis in Section 681 of these rules. This service may provide training and staff development related to the needs of a participant, and also provides emergency back-up involving the direct support of the participant in crisis. ( )

a. Children's crisis intervention services are provided in the home or other placement authorized by the Department. ( )

b. Children's crisis intervention is provided on a short-term basis typically not to exceed thirty (30) days. ( )

c. Children's crisis intervention services must be prior authorized by the Department. ( )

07. Family-Directed Community Supports. Participants eligible for children's waiver services may choose to family-direct their individualized budget rather than receive the traditional services described in this Section of rule. The requirements for selecting and participating in this option are outlined in IDAPA 16.03.13 "Consumer Directed Services." ( )

08. Service limitations. Children's waiver services are subject to the following limitations: ( )

a. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, community, or DDA. The following living situations are specifically excluded as a place of service for waiver services: ( )

i. Licensed skilled or intermediate care facilities, certified nursing facility (NF) or hospital; and ( )

ii. Licensed Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID); and ( )

iii. Residential Care or Assisted Living Facility; ( )

iv. Additional limitations to specific services are listed under that service definition. ( )

b. Medicaid Waiver services cannot be used to pay for special education and related services that are included in a child's Individual Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). The funding of such services is the responsibility of state and local education agencies. Section 1903(c)(3) of the Social Security Act provides that federal financial participation (FFP) is available for services, included in an IEP when such services are furnished as basic Medicaid benefits. Waiver

services are not considered to be basic Medicaid benefits. ( )

c. Children's waiver services are subject to the participant's individualized budget, excluding crisis intervention. ( )

d. For the children's waiver services listed in Subsections 683.01 through 683.07 of these rules, the following are excluded for Medicaid payment: ( )

i. Vocational services; ( )

ii. Educational services; and ( )

iii. Recreational services. ( )

684. CHILDREN'S WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All children's waiver services must be identified on the plan of service and authorized by the Department. The plan of service must be reviewed by a plan developer at least every six (6) months or at a frequency determined by the family-centered planning team. ( )

02. General Requirements for Program Documentation. Children's waiver providers must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant the following program documentation is required: ( )

a. Direct service provider information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: ( )

i. Date and time of visit; and ( )

ii. Services provided during the visit; and ( )

iii. A statement of the participant's response to the service, including any changes in the participant's condition; and ( )

iv. Length of visit, including time in and time out; and ( )

v. Specific place of service. ( )

b. A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ( )

03. Program Implementation Plan Requirements. For each participant receiving intervention services, the DDA must develop a program implementation plan to determine objectives to be included on the participant's required plan of service. All program implementation plan objectives must be related to a goal on the participant's plan of service. The program implementation plan must be written and implemented within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the intervention plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. The program implementation plan must include the following requirements: ( )

a. Name. The participant's name. ( )

b. Baseline. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. ( )

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives

previously identified on the required plan of service. ( )

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. ( )

e. Specific Service Environments. Identification of the type of environment(s) and specific location(s) where services will be provided. ( )

f. Target Date. Target date for completion. ( )

g. Supervisor Approval. The program implementation plan must be reviewed and approved by the DDA clinical supervisor. ( )

04. Reporting Requirements. The DDA must complete six (6) month and annual reviews for services provided. Documentation of the six (6) month and annual reviews must be submitted to the plan developer. ( )

05. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. ( )

06. Records Maintenance. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. ( )

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the following requirements: ( )

a. Habilitative intervention provider as defined in Subsection 685.03 of these rules; ( )

b. Therapeutic consultation provider as defined in Subsection 685.04 of these rules. ( )

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: ( )

a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; ( )

b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; ( )

c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; ( )

d. Advanced Registered Nurse Practitioner; ( )

e. Physician Assistant; ( )

f. Licensed Psychiatrist; ( )

g. Habilitative intervention provider as defined in Subsection 685.03 of these rules; ( )

h. Therapeutic consultation provider as defined in Subsection 685.04 of these rules. ( )

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to

provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and is capable of supervising the direct services provided. Providers of habilitative intervention must meet the following minimum qualifications: ( )

a. Must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college; ( )

b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; ( )

c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; and ( )

d. Must complete a supervised practicum; or ( )

e. Individuals certified as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Interventionists prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. Prior to June 30, 2013, the individual must meet the requirements of the Department-approved competency coursework. ( )

04. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of therapeutic consultation must meet the following minimum qualifications: ( )

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and ( )

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. ( )

c. Therapeutic consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

05. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of crisis intervention must meet the following minimum qualifications: ( )

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a degree in a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and ( )

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. ( )

c. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Section 665 of these rules. ( )

d. Crisis intervention providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

06. **Service Supervision**. The plan of service which includes all waiver services is monitored by the plan developer. ( )

07. **Requirements for Collaboration with Other Providers**. Providers of waiver services must coordinate regularly with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. ( )

08. **Requirements for Quality Assurance**. Providers of children's waiver services must demonstrate high quality of services through an internal quality assurance review process. ( )

09. **DDA Services**. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. In addition, the DDA may also opt to provide respite, habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. ( )

686. CHILDREN'S WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. **Fee-for-Service**. Waiver service providers will be paid on a fee-for-service basis based on the type of service provided as established by the Department. ( )

02. **Claim Forms**. Provider claims for payment will be submitted on claim forms provided by or approved by the Department. Billing instructions will be provided by the Department. ( )

03. **Rates**. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. ( )

687. -- 699. (RESERVED).

ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES (Sections 700 through 719)

700. ~~*INDIVIDUALS*~~ ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible adult participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID.
~~*(3-29-10)*~~( )

701. (RESERVED).

702. ADULT DD WAIVER SERVICES: ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following requirements: (3-29-10)

01. **Age of Participants**. DD waiver participants must be eighteen (18) years of age or older. (3-29-10)

02. Eligibility Determinations. The Department must determine that: (3-19-07)

a. The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and (3-19-07)

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. (3-19-07)

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs. (7-1-06)

d. Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (3-19-07)

03. Home and Community-Based Services Waiver Eligible Participants. A participant who is determined by the Department to be eligible for services under the Home and Community Based Services Waivers for DD may elect not to utilize waiver services but may choose admission to an ICF/ID. (3-29-10)

04. Processing Applications. The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/ID, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (3-19-07)

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (3-19-07)

06. Case Redetermination. (3-19-07)

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." Medical redetermination will be made at least annually by the Department, or sooner at the request of the participant, the self-reliance staff, provider agency, or physician. The sections cited implement and are in accordance with Idaho's approved State Plan with the exception of deeming of income provisions. (3-19-07)

b. The redetermination process will assess the following factors: (3-19-07)

i. The participant's continued need and eligibility for waiver services; and (3-19-07)

ii. Discharge from the waiver services program. (3-19-07)

07. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the home and community based waiver for developmentally disabled participants will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver of each new waiver year. (3-29-10)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to

reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-19-07)

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid

caregivers. (3-19-07)

04. Supported Employment. Supported employment which is competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (3-19-07)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation will be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or IDEA. (3-19-07)

b. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-19-07)

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-19-07)

09. Home Delivered Meals. Home delivered meals which are designed to promote adequate wavier

participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (3-19-07)

10. Skilled Nursing. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-19-07)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Care. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI. (3-19-07)

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.04<u>3.12</u>1, "Developmental Disabilities Agencies <u>(DDA)</u>." ~~*(3-19-07)*~~<u>( )</u>

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04<u>3.12</u>1, "Developmental Disabilities Agencies <u>(DDA)</u>." ~~*(3-19-07)*~~<u>( )</u>

13. Self Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

704. <u>ADULT</u> DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process described in Sections 507 through 520 of these rules. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. (3-19-07)

02. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: (3-19-07)

a. Direct Service Provider Information which includes written documentation of each visit made or

service provided to the participant, and will record at a minimum the following information: (3-19-07)

i. Date and time of visit; and (3-19-07)

ii. Services provided during the visit; and (3-19-07)

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (3-19-07)

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (3-19-07)

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 704.01 of these rules and a copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (3-19-07)

c. In addition to the plan of service, all providers, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Sections 507 through 520 of these rules. (3-19-07)

03. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (3-19-07)

04. Records Maintenance. In order to provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (3-19-07)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation. Residential habilitation services must be provided by an agency that is certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. Individuals who provide residential habilitation services in the home of the participant (supported living), must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (3-19-07)

a. Direct service staff must meet the following minimum qualifications: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

ii. Be a high school graduate or have a GED or demonstrate the ability to provide services according to an plan of service; (3-19-07)

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable diseases; (3-19-07)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-19-07)

b. All skill training for direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-19-07)

c. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-19-07)

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

d. Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-19-07)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

f. When residential habilitation services are provided in the provider's home, the provider's home must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider's provider agreement. (3-19-07)

02. Chore Services. Providers of chore services must meet the following minimum qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

03. Respite. Providers of respite care services must meet the following minimum qualifications: (3-19-07)

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)

b. Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)

c. Demonstrate the ability to provide services according to an plan of service; (3-19-07)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

f. Be free of communicable diseases. (3-19-07)

g. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

04. Supported Employment. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

05. Transportation. Providers of transportation services must: (3-19-07)

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations services must: (3-19-07)

a. Be done under a permit, if required; and (3-19-07)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)

07. Specialized Equipment and Supplies. Specialized Equipment and Supplies purchased under this service must: (3-19-07)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (3-19-07)

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-19-07)

09. Home Delivered Meals. Services of Home Delivered Meals under this Subsection may only be provided by an agency capable of supervising the direct service and must: ~~(3-19-07)~~( )

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)

d. Provide documentation of current driver's license for each driver; and (3-19-07)

e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

10. Skilled Nursing. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-19-07)

11. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-19-07)

b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

12. Adult Day Care. Providers of adult day care services must be employed by or be affiliated with the residential habilitation agency that provides program coordination for the participant if the service is provided in a certified family home other than the participant's primary residence, be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: (3-19-07)

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (4-2-08)

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

13. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

706. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. Fee-for-Service. Waiver service providers will be paid on a fee-for-service basis based on the type of service provided as established by the Department. (3-19-07)

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (3-19-07)